

Elementary school counselors' perceptions of the utility of play therapy

by

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B.A., Graceland University, 2013
M.S., University of Central Missouri, 2019

AN ABSTRACT OF A DISSERTATION

submitted in partial fulfillment of the requirements for the degree

DOCTOR OF PHILOSOPHY

Department of Special Education, Counseling, and Student Affairs
College of Education

KANSAS STATE UNIVERSITY
Manhattan, Kansas

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Abstract

Play is fundamental to the optimal growth and development of children. Utilizing play therapy with children who require mental health support and intervention is of significant benefit to the child, as it allows them to express their needs through play, their first language. School counselors who work with elementary-aged students may find play therapy to be a beneficial component of their comprehensive school counseling program. However, little is known about the use of play therapy by elementary school counselors, the training they have received in play therapy, or whether they perceive it as a useful intervention with their elementary-aged students.

This study utilized a one-group pretest-posttest design to learn about elementary school counselors' perceptions of play therapy utility and if providing information about play therapy changed these perceptions. Participants were a sample of practicing elementary school counselors in the United States ($n = 191$) who answered questions about the utility of play therapy both before and after receiving information about play therapy. Overall, participants found play therapy to be useful even before receiving information about it. Results indicated a statistically significant increase in the rating of play therapy utility after viewing a brief educational video about play therapy. These initial perceptions and the increase in perceptions did not vary significantly based on the community classification or low-income status of where an elementary school counselor worked, but statistical significances were detected based on the status of their reported training in play therapy. Implications of the findings and recommendations for future research and practice on this topic, including barriers to training in and use of play therapy by school counselors, are further discussed.

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Approved by:

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Chapter 1 - Introduction

This study explored the perception school counselors have about the utility of play therapy, whether exposure to brief information about play therapy had an impact on school counselors' perceptions, and the potential effect that previous training in play therapy had on their perception of its utility. This chapter will address (a) background information about the topic, (b) the need for the current study, (c) the current study's theoretical framework, (d) a statement of the problem, (e) the study's purpose and research questions, (f) hypotheses, (g) the study's significance, and (h) the definition of commonly used terms in this study.

Background

Play is so fundamental to the growth and development of children that it has been recognized by the United Nations High Commission for Human Rights as an inalienable right of childhood (United Nations Convention on the Rights of the Child, 1989). Play is a universal trait of children, and playful behaviors have been well-documented in children for centuries (Janssen & Janssen, 1996; Lowenfeld, 1939). Play is imperative for healthy brain development (Shonkoff & Phillips, 2000), language and cognitive development (Tamis-LeMonda et al., 2004), and has long been regarded as necessary for robust and healthy social (Pellegrini & Smith, 1998b), emotional (Erickson, 1985), and physical development (Pellegrini & Smith, 1998a). Additionally, recent longitudinal research not only highlights the importance of play in early childhood development, but also points to the long-term harm of early academic training in lieu of play-based learning, including an increase in disciplinary infractions, poor attendance, and a greater likelihood of qualifying for special education services later in childhood (Durkin et al., 2022).

Play is integral to the overall development of a child, is a child's first natural medium of communication, and is the most developmentally appropriate way for a child to communicate (Landreth, 2012). Because of this, the mental health needs of children are best served by providing children with a therapeutic intervention that is sensitive to and considerate of their developmental level (Landreth, 2012). Play therapy is to children what counseling is to adults. It utilizes play, the natural language of children, and the therapeutic relationship to provide a safe, consistent therapeutic environment in which a child can experience full acceptance, empathy, and understanding from the counselor and process inner experiences and feelings through play. Play therapy is traditionally implemented with children between the ages of two and 12 and provides a therapeutic format that accounts for a child's need to be physically active (Landreth, 2012).

Play therapy has been demonstrated to be effective in treating the mental and behavioral health needs of children, including trauma (Haas & Ray, 2020; Patterson et al., 2018), anxiety (Hateli, 2022; Smithee et al., 2021), depression (Li et al., 2016), attachment issues (Anderson & Gedo, 2013; Chen et al., 2021), aggression (Wilson & Ray, 2018), as part of a response to intervention (RtI) model within elementary schools (Winburn et al., 2017), and in supporting the academic achievement of elementary students (Perryman et al., 2020).

Need for the Study

School counselors are in a unique position to support the mental health needs of their student population and are charged with implementing comprehensive school counseling programs that maximize student success and promote equity and access for all students (American School Counselor Association; ASCA, n.d.). Their presence in the school setting removes common barriers to accessing mental health services, such as transportation, scheduling

conflicts, and stigma (ASCA, n.d.), and school counselors recognize they may be the only mental health professional available to students and their families (ASCA, 2020b), as the Health Resources and Services Administration (HRSA), an agency of the U.S. Department of Health and Human Services, has identified mental health providers as a critical shortage area (HRSA, 2022). Elementary school counselors typically serve students anywhere between the ages of four and 12, depending on the grade levels represented in the building, making their entire student population within the age group most likely to benefit from play therapy services. Additionally, with a national average school counselor-to-student ratio of 1:415 (ASCA, 2021) when ASCA (2021) recommends a 1:250 ratio, school counselors must be prepared with quality, short-term, and developmentally appropriate interventions for the students with whom they work.

Given the effectiveness of play therapy in treating the mental and behavioral health needs of children (Anderson & Gedo, 2013; Chen et al., 2021; Haas & Ray, 2020; Hateli, 2022; Li et al., 2016; Patterson et al., 2018; Smithee et al., 2021; Wilson & Ray, 2018) and supporting the academic achievement of students (Perryman et al., 2020; Winburn et al., 2017), it is a valuable approach that school counselors can use as they serve children. However, we have a very limited understanding of school counselors' knowledge of and training in play therapy. It is difficult to assess the percentage of counselor preparation programs that require coursework in play therapy as part of their graduate level training since the Association for Play Therapy (APT) does not maintain this kind of data (E. Gomez, personal communication, April 4, 2022). However, according to The Council for Accreditation of Counseling and Related Educational Programs (CACREP; 2022), 272 programs are accredited as master's-level school counseling programs. APT (2022b) reports only 156 universities that offer coursework in play therapy, and of those 156, only 71 of these universities are found in the 272 university programs identified as

CACREP-accredited school counseling programs. Based on this data, only approximately 26% of school counselor preparation programs provide their students with coursework and training in play therapy; however, the actual percentage is likely much lower than 26% as APT does not delineate between university programs that offer only a post-graduate certificate in play therapy from those who offer or require a class in play therapy as part of their master's-level coursework, nor are all counselor preparation programs CACREP-accredited. In short, most school counselor preparation programs do not offer any coursework in play therapy.

Several meta-analyses that have been conducted on prior play therapy studies point to its efficacy in a variety of settings and across a variety of presenting problems, including play therapy in the school setting (Ray et al., 2015), with behavioral disruptions (Parker et al., 2021), in supporting language development in young children on the autism spectrum (Boerio, 2022), among others (Leblanc & Ritchie, 2001; Bratton et al., 2005; Jensen et al., 2017; Pester et al., 2019; Wiersma et al., 2022). Moreover, providing treatment interventions that are developmentally appropriate and effective is a mandate set forth by both the American Counseling Association's Code of Ethics (ACA; 2014) and ASCA's (2016) Ethical Standards for School Counselors. Because of this, when children require mental health interventions, it is necessary for mental health professionals to be equipped with a skillset that meets the developmental level of the client whom they are servicing. Without exposing school counselors and students in counselor preparation programs to information about or training in play therapy, they may not have the opportunity to develop a skillset that will best serve their students. This study will provide valuable insight into the perceptions elementary school counselors have about play therapy and its utility, which may have implications regarding how school counselors are trained in the future.

Theoretical Framework

Child-Centered Play Therapy (CCPT) is a developmentally appropriate, therapeutically-attuned, play-based mental health approach for children ages 2 to 12 who are experiencing social, emotional, behavioral, and relational disorders (Landreth et al., 2009). Play, a child's first and most natural language, and the therapeutic relationship are utilized in CCPT to provide a safe, consistent therapeutic environment in which a child is able to experience full acceptance, empathy, and understanding from the counselor and process their inner experiences and feelings. Because the child's world is a world of action and activity, play therapy provides the therapist with an opportunity to enter the child's world. The toys are like the child's words, and play is the child's language (Landreth et al., 2009). The child is not restricted only to discussing their thoughts and feelings; rather, the child lives out at the moment of play past experiences and associated feelings. Of the several well-established play therapy schools of thought, CCPT has the longest history of use, the strongest research support, and the largest number of followers (Landreth et al., 2009).

Statement of the Problem

Play therapy is frequently discussed in the counseling field as the most developmentally appropriate way to meet the mental health needs of children in school settings (Landreth, 1993; Drewes & Schaefer, 2010; Ray et al., 2005) and as the most therapeutically attuned (Landreth, 1987; Winburn et al., 2017) and culturally sensitive (Ceballos et al., 2021) intervention of a comprehensive school counseling program. Despite the strong empirical evidence, there are no current quantitative studies that examine the perception school counselors have of the utility of play therapy or the impact that training in play therapy may have on the perception of its utility by school counselors. Additionally, only one study has explored the perceptions of the utility of

play therapy by the adult public (Hindman, 2020; Hindman et al., 2022) and only one qualitative study looked at school counselors' and counselor educators' perceptions of play therapy, which was done in relation to its perceived compatibility with Chinese culture (Shen & Herr, 2003).

Purpose and Research Questions

The purpose of this study was to explore the perceptions school counselors have about the utility of play therapy and whether exposure to information about play therapy had an impact on these perceptions. The study further explored whether prior training in play therapy had an impact on school counselors' perception of its utility. It was reasonable to expect that school counselors with prior training in play therapy would have a more informed and perhaps more favorable view of play therapy than those who did not have any prior training in play therapy. This study also explored if there was a relationship between the population a school counselor served and their perceptions of play therapy. As play therapy training offerings are limited, it was believed to be beneficial to explore if there was a relationship between the community classification where an elementary school counselor was employed and their perceptions of play therapy. Additionally, participants were asked about the low-income status of the population they serve. This was done to gain insight into the approaches school counselors who work with low-income families have used with their students, as research has indicated a relationship between low levels of household income and several lifetime mental disorders (Sareen et al., 2011).

The following questions will be addressed by this study:

1. What is the initial perception of play therapy by elementary school counselors?
2. Does this initial perception vary based on three background variables: community classification, Title I status, and self-reported training in play therapy?

3. Does exposure to information about play therapy significantly change elementary school counselors' perceived utility of play therapy services?
4. If there is a change in perception, does this vary based on three background variables: community classification, Title I status, and self-reported training in play therapy?

Significance of the Study

Play therapy interventions are critical elements of providing responsive services within the context of comprehensive school counseling programs (Curry & Fazio-Griffith, 2013), particularly in the elementary setting. However, most school counselors have not received any training in play therapy as part of their graduate-level coursework in their counselor preparation program. Results from this study provide meaningful information about elementary school counselors' perceptions of the utility of play therapy, a developmentally appropriate treatment modality for children in the age group served by elementary school counselors. Additionally, this study provides insight for counselor educators and counselor education programs to consider regarding their provision of play therapy training for students who intend to work with children in clinical or school settings.

Definition of Terms

Comprehensive School Counseling Program: A comprehensive school counseling program, "is an integral component of the school's mission. Informed by student data and based on the ASCA National Model, school counseling programs are provided by a state-credentialed school counselor and:

- are delivered to all students systematically
- include a developmentally appropriate curriculum focused on the mindsets and behaviors all students need for postsecondary readiness and success

- close achievement and opportunity gaps
- result in improved student achievement, attendance and discipline” (ASCA, 2017).

Play Therapy: “...a dynamic interpersonal relationship between a child (or person of any age) and a therapist trained in play therapy procedures who provides selected play materials and facilitates the development of a safe relationship for the child (or person of any age) to fully express and explore self (feelings, thoughts, experiences, and behaviors) through play, the child’s natural medium of communication, for optimal growth and development” (Landreth, 2012, p. 11).

Registered Play Therapist: a credential conferred by the Association for Play Therapy that allows consumers of mental health services to identify professionals with specialized experience and training in play therapy including an integration of play therapy instruction, clinical experiences, and supervision (APT, 2021).

Registered Play Therapist – Supervisor: the RPT-S designation represents an advanced level of expertise, as evidenced by ongoing practice and continued education, in the field of play therapy. This credential conferred by APT allows for the provision of play therapy supervision to those mental health professionals seeking the Registered Play Therapist (RPT), Registered Play Therapist–Supervisor (RPT-S), or School Based-Registered Play Therapist (SB-RPT) (APT, 2022a).

School-Based Registered Play Therapist: a credential conferred by APT upon licensed or certified school counselors or school psychologists who do not hold a state-board issued mental health license to help consumers identify those with specialized training and experience in play therapy (APT, 2020).

Summary

This chapter presented information about the current study, which evaluates elementary school counselors' perceptions of the utility of play therapy. This study has implications regarding the training and preparation of school counselors in the future and the course offerings of counselor-preparation programs. In the following chapter, what is known in the literature about play therapy, its foundational theories, the value of play therapy, and existing studies about the use of play therapy in the school setting will be presented.

Chapter 2 - Literature Review

This study explores the perception school counselors have about the utility of play therapy, whether exposure to brief information about play therapy has an impact on school counselors' perceptions, and the potential effect that previous training in play therapy may have on their perception of its utility. This chapter includes a review of the literature on seminal and historically significant play therapy theories, the value of play therapy, and existing studies about the use of play therapy in the school settings.

The History and Development of Play Therapy

Prior to the industrialization of the late 19th century, children were often viewed as possessions and a source of income for a family, and childhood was not viewed as a unique phase of life. Once families could begin attending to their quality of life and socioeconomic status no longer had as much of an influence on whether a child worked all day or was able to receive an education, psychotherapists began to turn their attention to the mental health needs of children and began viewing and treating adult mental illness in light of causative factors from childhood (Johnson, 2015). The founding of the National Committee for Mental Hygiene (NCMH) in 1909 was a catalyst for this school of thought and led to the development of mental hygiene programs in schools and therapeutic services for children in communities (Johnson, 2015). That same year, Sigmund Freud presented his now-famous publication on the psychoanalysis of Little Hans (Kottman, 2011b), and Carl Jung presented the case of Anna, which was based on his four-year-old daughter. These events are identified as the genesis of child psychotherapy in the United States (Johnson, 2015). Hermine Hug-Hellmuth (1921) is widely regarded as having the first documented accounts of using play therapy with children around 1913, where she observed child play and documented her interpretations of it (Geissmann

& Geissmann, 1998; Kottman, 2011b). Anna Freud (1928, 1946, 1965) is also regarded as an early adopter of play therapy, but only viewed play as a way to establish a relationship with the child, not a way for the child to communicate in a metaphoric or symbolic manner (Kottman, 2011b). It is Virginia Axline (1947) who is credited as the true mother of play therapy. A student of Carl Rogers (1951), Axline integrated the tenets of Rogers's non-directive and client-centered approach into play-based work with children during the 1940s (Homeyer & DeFrance, 2004; Johnson, 2015), which became the basis for nondirective play therapy, what is now known as child-centered play therapy (Landreth, 2012).

By the 1970s, nearly 100 varying models of psychotherapy existed (Seymour, 2015) with competing claims of efficacy. Simultaneously, the research surrounding child development had been steadily growing since the 1950s, and some practitioners were beginning to integrate this burgeoning field of research into their approach to child psychoanalysis. During this time, behavioral models were becoming very popular, which was a shift away from the dynamic and relational processes that had characterized the field up until that point (Seymour, 2015). These developments resulted in the mental health community calling for more dialogue between practitioners and researchers, model integration, and accountability for therapeutic practices and outcomes (Seymour, 2015).

Into the 1980s, play therapy was being practiced by child therapists from a wide range of theoretical orientations. The variety of models of play therapy made for a robust selection of therapeutic offerings for children; however, it simultaneously made it challenging for the field of play therapy to provide a cohesive response to competing trends that challenged the use and effectiveness of play therapy as a form of child psychotherapy (Seymour, 2015). In 1982, Charles Schaefer and Kevin O'Connor co-founded and formed the Association for Play Therapy

as a way for play therapists to network, offer and receive training, and collaborate on research (APT, 2011). Over time, the founders' vision has been realized, and APT has become a strong professional organization built on a combined foundation of practice and research.

As the field of play therapy has progressed, seminal and historically significant theoretical approaches to play therapy have emerged. These evidence-based orientations to play therapy integrate the therapeutic powers of play with clinical theory and practical approaches.

Adlerian Play Therapy

Adlerian Play Therapy (AdPT; Kottman & Meany-Wallen, 2016) draws on the core concepts of Alfred Adler's (1931) individual psychology and combines it with the age-appropriate approach of using toys, puppets, art supplies, stories, and role-playing as a child's natural medium of communication. The theoretical constructs of AdPT are based on Adler's assertion that people are socially embedded, goal-directed, subjective, and creative beings (Kottman, 2011a; Kottman & Ashby, 2015). Play therapists are tasked with the job of identifying how children fit into their social relationships — or, in other words, how they are socially embedded — and how the child's interaction in those relationships help or hinder their sense of purpose. Adlerian play therapists often conceptualize child misbehavior as achieving one or more of four goals: attention, power, revenge, and proving inadequacy (Kottman, 2001). Behavior in the playroom in conjunction with parent reports help Adlerian play therapists choose interventions to address the misbehavior in the third and fourth phases of therapy, which will be described in more detail below. Insight into this behavior helps the play therapist create goals to help the child achieve what Lew and Bettner (1996, 1998) describe as "Crucial Cs," which include a child's need to feel connected, capable, that they count, and can demonstrate courage.

Adlerian play therapy has four phases, which include building an egalitarian relationship with the client, exploring the client's lifestyle, helping the client gain insight into his or her lifestyle, and providing reorientation and reeducation for the client when necessary (Kottman, 2011b). All work is done with a positive and pro-active view of the child and his or her capacity for change (Kottman, 2011b). In the first phase, it is likely that the child will not change or will change very little. This stage focuses on connecting with the child and developing a safe and therapeutic relationship, and as such, the only change a child may experience is their willingness to engage in a relationship with an adult (Kottman, 2001). The therapist also prioritizes building a relationship with the child's parents, with little expectations for them to change or alter their parenting approach.

In the second phase, the therapist begins to explore the lifestyle of the child and his or her parents. During this phase, the therapist has the expectation that the child will answer questions and play out the various aspects of his or her lifestyle and that the parents will answer questions about the child, the parents' family-of-origin, the marital relationship, family values, parenting methods, and more (Kottman, 2001). While this phase is the beginning of more directive work, there is little, if any, pressure from the play therapist for the child or parents to change, although change may occur in light of insight development during the exploration process (Kottman, 2011b).

The third phase signals a significant shift in the Adlerian play therapist's expectations of change, both from the child and from the parent(s). The play therapist will simultaneously attempt to help the child gain a better understanding of his or her lifestyle and guide the client towards appropriate changes while also working with the parents on gaining a better understanding of their child and of their own lifestyle issues that might be interfering with their

ability to be the best parents they can be (Kottman, 2001). As the child and parent begin to adopt some of these changes and begin making major shifts in their attitudes toward themselves, one another, other people, and the world in preparation for the fourth phase.

The fourth and final phase of AdPT brings the greatest expectation for change. All the new skills, attitudes, and ways of being in the world that the child and his or her parents have learned are now being put into practice through the way they view the world, their attitudes about the world and relationships with others, and practicing these new attitudes and approaches with the play therapist to prepare for portability outside of the therapeutic relationship. In the fourth phase, the play therapist uses teaching techniques, such as brainstorming, modeling, sharing metaphors, role-playing, and playing games, and encouraging skills focused on the improvement and effort of the child and the parents (Kottman, 2001).

One of the most distinctive features of AdPT is that the approach is both non-directive and directive, depending upon which phase of therapy the client and family is in and the goals of therapy. The decision to be non-directive or directive is both fluid and systematic, making this kind of flexibility unique to this approach (Kottman, 2011b).

Child-Centered Play Therapy

While there are many approaches and theoretical orientations within the field of play therapy, child-centered play therapy has the most extended history of use and the most substantial research base to support its efficacy (Glover & Landreth, 2016; Landreth, 2012). It is also the most frequently used methodology among currently practicing play therapists (Landreth, 2012). Based on the client-centered work of Carl Rogers (1951), Virginia Axline (1947), a student and colleague of Rogers, adapted Rogers's client-centered work to use in play-based approaches as a developmentally appropriate approach that, like client-centered therapy, is

focused on a way of being with the child rather than a procedure of application (Sweeney & Landreth, 2003).

Child-centered play therapy is predicated on the belief that the relationship that develops between the helping professional and the child is the activating agent for therapeutic growth, healing, and change (Glover & Landreth, 2016; Ray & Bratton, 2016; Ray & Landreth, 2015). The play experience is therapeutic due to the safety and trust established between the counselor and child, allowing the child to fully express themselves and lead in all areas of the counseling relationship (Axline, 1947; Landreth, 2012). Child-centered play therapists resist any urge to direct a child's play or conversation (Landreth 2012) and are not interested in focusing on symptoms, problems, diagnosis, or prescriptive techniques (Landreth & Sweeney, 1999, 2001; Sweeney & Landreth, 2003). Instead, the focus of the child-centered play therapist is on facilitating a process that allows the child to embark on a journey of self-exploration and self-discovery (Landreth & Sweeney, 1999). Axline (1947), who is largely regarded as the pioneer of modern non-directive play therapy, outlines eight essential principles for non-directive play therapists:

1. The therapist must develop a warm, friendly relationship with the child, in which good rapport is established as soon as possible.
2. The therapist accepts the child exactly as he is.
3. The therapist establishes a feeling of permissiveness in the relationship so that the child feels free to express his feelings completely.
4. The therapist is alert to recognize the feelings the child is expressing and reflects those feelings back to him in such a manner that he gains insight into his behavior.

5. The therapist maintains a deep respect for the child's ability to solve his own problems if given an opportunity to do so. The responsibility to make choices and to institute change is the child's.
6. The therapist does not attempt to direct the child's actions or conversation in any manner. The child leads the way; the therapist follows.
7. The therapist does not attempt to hurry the therapy along. It is a gradual process and is recognized as such by the therapist.
8. The therapist establishes only those limitations that are necessary to anchor the therapy to the world of reality and to make the child aware of his responsibility in the relationship. (pp. 73-74)

As such, child-centered play therapy is well-suited for children from diverse backgrounds and with a wide range of presenting problems (Green & Kolos, 2009). A child-centered play therapist imposes no pressure on the child to change and views all behavior as a vehicle for the child to achieve full self-realization (Axline, 1947; Landreth, 2012).

Change in the child's behavior or presenting problem is achieved through the accepting nature of the helping professional and the safety of the playroom where sessions take place (Green & Kolos, 2009). This environment is what allows the child to develop internal resources for self-regulation, self-control, self-acceptance, and self-reliance that can transfer to situations outside of the therapeutic setting to help the child make better decisions, demonstrate greater empathy, and meet life's challenges (Ray & Bratton, 2016; Green & Kolos, 2009). This journey of self-exploration for the child is what allows them to find within themselves the resources to solve problems and heal (Landreth & Sweeney, 1999, 2001) and establishes the permissiveness

and acceptance needed for the child to choose a path towards growth, healthy functioning, and mature behavior (Axline, 1947; Ray & Landreth, 2015; Sweeney & Landreth, 2003).

Cognitive Behavioral Play Therapy

Cognitive Behavioral Play Therapy (CBPT) is centered on the theoretical tenets of cognitive behavioral therapy (CBT; Knell, 2011) and was developed as an age-appropriate approach that integrates play into the well-researched, evidence-based, and empirically-validated treatment approach of CBT (Drewes & Cavett, 2019; Knell, 2016). CBT focuses on how emotions, behaviors, and cognitions interact with one another (Beck & Emery, 1985) and how these interactions shape both an individual's experiences in (Beck, 1967, 1972, 1976) and perceptions of (Knell, 2016) their world.

Like other approaches to play therapy, CBPT is intended to be conducted in a typical playroom setting. However, CBPT is a directive and goal-oriented approach (Knell, 2011; Knell, 2016) intended to target and change any undesired or maladaptive thoughts or behaviors in the child (Drewes & Cavett, 2019). Techniques such as bibliotherapy, puzzles, games, puppets, storytelling, and drawing may be used to help children replace old behaviors with new ones, address distorted or maladaptive thoughts, and reduce symptoms across a variety of settings (Drewes & Cavett, 2019; Knell, 2016). Unlike non-directive forms of play therapy, children participating in CBPT need a secure place to store personal projects between sessions (Knell, 2016) as some directive play therapy interventions may be completed over the course of multiple visits to the playroom. However, CBPT does not always have to be conducted in a playroom (Knell, 2016). As this modality is more directive than some others, a play therapist can utilize play-based approaches by providing only the supplies necessary for the directive play intervention, regardless of the therapeutic setting. A therapist may also determine that in-vivo

treatment is more beneficial for the child based on their presenting problem. Knell (2016) provides some examples of when in-vivo treatment may be appropriate: a child dealing with school refusal may be best treated in or near the school, a child who has a fear of toileting may benefit from a portion of their therapy experience occurring in an actual bathroom, or a child who is fearful of dogs may begin to deal with that fear or anxiety in the presence of a therapy dog.

Like AdPT, CBPT treatment progresses through four stages: orientation, assessment, middle, and termination (Knell, 2016). During the orientation stage, the child's parents or guardians may provide some information to their child about play therapy after they have met with the play therapist during the intake process (Knell, 2016). Additionally, the play therapist will dedicate some time during the first session to talk with the child about how play therapy might be able to help them with some of the difficulties they are experiencing (Knell, 2016).

During the assessment stage, the play therapist may use formal or informal assessment measures (Knell, 2016) ranging from diagnostic instruments or behavioral rating scales answered by parents to observing the child's play. Typically, informal assessment procedures, like play observations, are favored with younger, preschool-aged clients as most formal assessments are validated with and developed for school-aged children (Knell, 2016). The play therapist will use these assessments to formulate a treatment plan and identify a diagnosis.

During the middle stage, the play therapist considers the how the treatment plan and identified goals will guide the therapeutic process. Of the many techniques and intervention methods that can be used with CBPT, the primary technique utilized is modeling, which is often facilitated through puppets and bibliotherapy (Knell, 2016). This intervention can help children with the cognitive restructuring necessary to alleviate symptoms by providing an example of the

behavior to be learned (Knell, 2016), which impacts the child's feelings and thoughts about their problem as well (Drewes & Cavett, 2019; Knell, 2016). The middle stage includes both structured and unstructured play, and the CBPT play therapist will use both to help enact change within the child: unstructured play gives the play therapist an opportunity to observe the child, which can lead to insight about a child's thoughts and feelings, while more structured play activities are used to teach specific skills and target specific behaviors (Knell, 2016).

Termination, the final stage of CBPT, should be a gradual process and even celebratory in nature. During this phase of the therapeutic process, it might be beneficial for the child to have a calendar or create a paper-chain countdown to the end of therapy (Knell, 2016). Some children may benefit from an appropriate disclosure from the play therapist about how proud they are of the child and how happy they are that the child is feeling better (Knell, 2016). Reminders of an open-door policy, an invitation for parents or the child to reach out to share future accomplishments, normalizing the experience of saying goodbye, and suggestions for staying in touch can all be helpful, even if not used (Knell, 2016).

Ecosystemic Play Therapy

As the name suggests, Ecosystemic Play Therapy (EPT) is ecosystemically grounded, and every component of a case – including assessment, case conceptualization, and intervention evaluation and implementation – is wholly dependent on the context of the client's story, their family, and the unique aspects of their life in which they are embedded (O'Connor, 2016; O'Connor & Braverman, 2009). EPT is described as an "integrative metatheory" (O'Connor, 2016, p. 196) that draws on solid decision-making models to intentionally choose and integrate specific theoretical approaches and techniques that will best serve the client. Developed in the late 1980s by Dr. Kevin O'Connor, co-founder of the Association for Play Therapy, EPT

recognizes that children undergo very rapid development, and as such, the play therapist must both be prepared for and support these developmental changes (O'Connor & Vega, 2019).

Ecosystemic play therapists are guided by six basic tenets. As mentioned previously, they always maintain an ecosystemic perspective with the client. Second, EPT emphasizes the importance and centrality of the client-therapist relationship much like CCPT; however, an ecosystemic play therapist take a much more active role, assuming full responsibility in all aspects of the play session and always remaining engaged with the child and their play (O'Connor, 2016).

Third, EPT does not lie solely at one end or the other of the directive to non-directive spectrum. Instead, play therapists who operate from an ecosystemic perspective structure sessions in a way that is “inversely proportional to the developmental level of the child” (O'Connor, 2016, p. 198). In other words, sessions with very young children who lack the ability to self-regulate may look very directive in nature to provide the high-level of structure, safety, and consistency that is developmentally appropriate and required for optimal growth and development of this age group. Likewise, an ecosystemic play therapist may take a more non-directive approach with older children to allow them the freedom to explore and creatively problem solve through play (O'Connor, 2016).

Fourth, EPT subscribes to neither solely a experiential approach to play therapy nor a cognitive-verbal approach. Much like how play therapists operating from an ecosystemic perspective will take the developmental abilities of the child into account when considering either directive or non-directive approaches to play, EPT considers the developmental level of the child in conjunction with their therapeutic goals when deciding whether the child will

experience the most growth through an experiential approach for a cognitive approach (O'Connor, 2016).

Fifth, EPT views the playroom as a space that does not hold any therapeutic value in and of itself, but rather, a “neutral container for the therapeutic relationship” (O'Connor, 2016, p. 199). Additionally, children are not given unrestricted access to all toys or play materials in the playroom of an ecosystemic play therapist. Instead, the play therapist is intentional in selecting what the child can access. This serves several purposes from the EPT perspective: first, a limited number of toys intentionally selected for a specific child's therapeutic benefit means the play therapist is less likely to have to set limits with the child. (O'Connor, 2016). Additionally, limiting the number of toys prevents the child from becoming so overwhelmed by available play materials that they are unable or unwilling to interact with the therapist, which is core to the EPT approach (O'Connor, 2016). This intentional, limited selection is also designed so the child can not engage in play simply to avoid the necessary work designed to help the child achieve their therapeutic goals; thus, limiting the toys available helps the child to focus on engaging in the therapeutic process (O'Connor, 2016).

Sixth, and finally, ecosystemic play therapists are far more explicit and intentional in partnering with the child and his or her caregivers to create a specific treatment contract with the child. O'Connor (2016) notes that the agreement with the child may or may not be what urged the parents to bring the child to treatment: for example, parents may be concerned about a child's aggressive behaviors, but these behaviors may provide a sense of control for the child that they will likely be unwilling to relinquish. Instead, the ecosystemic play therapist may recognize that the child is experiencing a high level of distress or anxiety and enact a treatment contract with the child by simply saying, “I know you don't like feeling worried and nervous so much of the

time. You and I will work together so you spend less time worrying and have more time to play and have fun” (O’Connor, 2016, p. 199).

Another aspect of EPT that is not explicitly tied to process of therapy is the idea of the play therapist taking on a variety of roles as necessary during the therapeutic process. Since the ecosystemic lens views clients through the system in which they are embedded – much like AdPT – the play therapist may also take on the role of a family therapist, advocate, or consultant with other various stakeholders in the child’s life, such as teachers, legal representation, or medical professionals (O’Connor, 2016). Ecosystemic play therapists always take caution when moving into a role beyond that of the play therapist and will empower parents or caregivers to advocate for the child and take on these roles when appropriate, necessary, and within the capacity of these adults in the child’s life to do so (O’Connor, 2016).

Gestalt Play Therapy

The basis for Gestalt play therapy is rooted in the psychotherapeutic work of Fritz Perls (1975) who famously wrote, “The criterion of a successful treatment is the achievement of that amount of integration that leads to its own development” (pp. 52-53). This idea of purposeful balance and integration of self is at the core of the tenets of Gestalt therapy. “Gestalt” is a German term and concept that has no English equivalent but is regarded as a concept that considers the whole in terms of shape, pattern, form, and configuration (Blom, 2006). In the 1970s, Violet Oaklander began to use her newfound training in Gestalt therapeutic approaches and techniques and integrated them with creative approaches – such as working with model clay, sand, puppets, and art – with the children she taught in her classroom for emotionally disturbed children (Carroll & Orozco, 2019). This was the birth of what is now known as Gestalt play therapy, which weaves play-based and creative approaches with the dynamic, present-centered,

humanistic, and process-oriented mode of therapy that is central to the Gestalt approach (Oaklander, 2001).

Two of the major tenets of Gestalt play therapy are organismic regulation and dialogic process (Carroll & Orozco, 2019). Organismic regulation recognizes that an organism, or an individual, will constantly seek homeostasis, health, and wellness without exception. The Gestalt play therapist considers this and understands that children will react to events that threaten their wellness – such as trauma, anxiety, family dysfunction, crisis, or loss – in whatever way necessary to return to homeostasis, and usually in predictable ways based on their developmental level (Oaklander, 2001). As a way for the child to get their needs met, and because of a child’s intellectual and emotional immaturity and narrow understanding of the world, they will often develop dysfunctional ways of being in the world that they perceive will meet their needs and return them to homeostasis, only to make things more difficult for them (Blom, 2006; Oaklander, 2001). Oaklander (2001) provides an example of a child who learns that their expressions of anger are unacceptable, so to meet their need of acceptance and approval, the child entirely suppresses their anger instead learning safe or acceptable ways to express and release it. This, of course, can lead to an even greater degree of disequilibrium beyond the child’s awareness, such as headaches, stomach aches, withdrawing socially, inflicting self-harm, etc. The Gestalt play therapists recognizes these symptoms as underlying a greater need for the child to achieve wellness and proceeds with treatment accordingly. The dialogic process the recognition of engaging in a therapeutic relationship where the child and the play therapist are impacted by each other (Carroll & Orozco, 2019). This requires a fully present and engaged play therapist and that therapist’s ability to sense and respond to the child’s experiences as expressed through multiple modalities: language, play, mannerisms, etc. It is when the therapist and child mutually

confirm meaning of these experiences that allows the therapy process to both deepen and begin to produce the child's movement back to homeostasis (Blom, 2006; Carroll & Orozco, 2019).

The goal of Gestalt play therapy is for the child to experience integrated wellness (Carroll & Orozco, 2019). This requires the child's healthy functioning in all domains: physical, mental, emotional, and intellectual. Through the elements of the Gestalt play therapy process, which can include making contact, strengthening a sense of self, understanding emotions and emotional expression, accepting oneself, experimenting with new ways to meet one's needs, and building appropriate support, the child becomes integrated with themselves. Gestalt play therapists use many modalities of directive play that may include sand tray work, puppets, role playing, homework, sensory activities, or role play to help the child regulate emotions, be an engaged learner, and develop and maintain meaningful relationships (Carroll & Orozco, 2019; Oaklander 2001).

Jungian Analytical Play Therapy

Jungian Analytical Play Therapy (JAPT) has its basis in the Jungian ideas of personality development, which suggests that an individual's conscious and unconscious have a "fluid yet regulated" communication with each other (Allan, 1997, p. 101). In addition to the conscious and unconscious, the ego is the third component that makes up the structure of the psyche according to Jungian analysts, and an understanding of the process of this ego development is central to understanding the JAPT approach (Lilly & Heiko, 2019). Therapists who practice from a Jungian perspective believe an individual's ego mediates between the conscious and unconscious, and that the ego gains strength through encountering new or stressful events and healing itself once skills are learned and utilized to resolve tensions following new or stressful events (Fordham, 1973). JAPT promotes psychical healing by emphasizing the significance of the therapeutic

relationship and encouraging the emergence of the self-healing archetype that is embedded within children's psyches (Green, 2005).

The JAPT approach subscribes to the idea that the child possesses all the therapeutic healing and power needed for transformational change (Lilly & Heiko, 2019). The unconscious houses the source of that change, and for children, the change and healing come from the symbolic process of play. Children are empowered by play to give a voice to otherwise difficult or unspeakable experiences in order to achieve healthy functioning (Lilly & Heiko, 2019). The Jungian play therapist believes that once the child's self-healing archetype can emerge because of the safety and trust created in the playroom, children will begin to play out significant and symbolic play themes that reflect their inner turmoil (Green, 2005). JAPT can be non-directive or semi-directive, the latter often being semi-directive drawing prompts; however, the play therapist should consider the developmental level of the child in conjunction with beneficial play activities to facilitate a robust therapeutic experience with the child. While providing a child with limited toys was an early approach to analytic play, more recent schools of thought tend to suggest that all play materials have the potential to elicit dynamic material, and the attuned analyst will be able to keep an open mind and allow the child's choice to lead to further understanding (Punnett, 2016). Additionally, a strong therapeutic alliance with the child's parents is of the utmost importance to ensure they do not terminate therapy prematurely and at the first sign of improvement. While improvement is a promising sign, the work must consolidate for the new behaviors to become habits and patterns in a child's life (Punnett, 2016), and this should be discussed with the parents or caregivers early in treatment to avoid a rupture in the therapeutic work later.

The primary goal of JAPT is for the child to return to healthy and developmentally appropriate functioning (Green, 2005). This is achieved by providing the client with the autonomy to express repressed emotional anguish while the play therapist serves as an observer-participant that harnesses the child's creative expression to bolster available ego-energies (Allan & Bertoi, 1992; Green, 2005). JAPT practitioners strive to understand the symbolism present in a child's play and assist the child in recognizing the resolution of tensions and complexes by making the unconscious conscious (Lilly & Heiko, 2019).

Psychoanalytic Play Therapy

The key concept of psychoanalytic play therapy is the exploration of the unconscious (Punnett & Green, 2019). Early analysts viewed play as a developmentally appropriate way to access a child's unconscious. They recognized that children who presented with neurotic tendencies would not be able to engage in traditional free association in the same way adults could, namely, lying on a couch and engaging in an adult-oriented therapeutic process (Levy, 2011). Analysts considered that play could allow the child to relax, providing an opportunity for the ego to loosen its control over previously suppressed and conflictual material, allowing it to be brought to the child's consciousness. They also recognized that play is often symbolic and could be analyzed in a similar manner to dream analysis in adult psychotherapy, and that a play setting would allow both a child to express their fears naturally and the analyst to observe and interpret their play (Levy, 2011). The idea of psychoanalytic play therapy was to adhere as closely as possible to the model of psychoanalysis that was used with adults, as the idea of accessing the unconscious to deal with neuroses was considered a ground-breaking treatment approach during the 1930s and 1940s (Levy, 2011).

Melanie Klein (1955), believed to be one of the first psychoanalysts to treat children through play, suggested that therapeutic play in children was the equivalent of free association exercises with adults. In her work, she observed that children, like adults, experience transference with their therapist and the child's play will reveal the root of their conflicts and neuroses (Klein, 1955). This approach established interpretation and analysis as fundamental to understanding the child's presenting problems, as this interpretation and analysis is how the analyst facilitates contact with the child's unconscious, and helping to free the child's imagination (Klein, 1932). However, Anna Freud (1946) believed that a child's play could not be as certain as language, and therefore, could not be touted as the equivalent of free association in adult clients. Additionally, she did not subscribe to the idea that children could experience transference with their therapist for two reasons: first, the child's relationship with their parents precluded them from transposing neurotic conflicts onto the therapist, and second, she believed the therapist could not function as a blank screen upon which children could project their internal conflicts (Freud, 1965). However, all analytic therapists seem to acknowledge that their relationship with the child, regardless of how it is conceptualized, is an integral component of the therapeutic process.

In psychoanalytic play therapy, the play therapist and their psychoanalytic approach tend to be more of a professional posture taken on by the therapist as opposed to a specific set of interventions or techniques (Punnett & Green, 2019). While the goal in psychoanalytic play therapy is to express, interpret, and treat preconscious and unconscious material (Levy, 2011) as a way to help children develop their unique identities so they can meet the goals of their family, school, and society (Punnett & Green, 2019), contemporary psychoanalytic play therapists also recognize that engaging with the child directly through play can be therapeutic in and of itself

(Levy, 2011). As both psychoanalysis and psychoanalytic play therapy progressed, play became viewed as an activity that is neither fully intrapsychic nor fully a child's external reality (Winnicott, 1971). As such, contemporary psychoanalytic play therapists tend to use interpretation judiciously (Winnicott, 1971) and recognize the inherent therapeutic qualities of play as creating space in the therapeutic relationship for the child to metaphorically utilize the relationship with the analyst as needed to advance their development.

Play Therapy in Schools

Within schools, the use of play therapy can be valuable. Particularly at the elementary level, where students have yet to reach a developmental level that allows them to fully express themselves verbally, play serves as a significant form of communication (Landreth, 2012) between the student and the counselor. However, mental health professionals who advocate for the use of play in the school setting must demonstrate a connection to school success (Sweeney et al., 2014). This connection must be established because the primary objective of schools is to provide adequate learning opportunities through early experiences that shape behavior patterns, interactions with others, and the intellectual, emotional, social, and physical development of children (Landreth 2012; Ray & Bratton, 2016). Children can succeed in academics when they feel safe, experience positive relationships, and develop social and emotional resiliency (Ray & Bratton, 2016; Sweeney et al., 2014), all known benefits of play therapy (Landreth, 2012; Swank, 2014). This makes play therapy a preferred modality for counseling elementary-aged children as it is this age group's "most effective form of communication" (Ray, 2011, p. 1). Providing it in schools utilizes the child's natural setting as an avenue for early intervention (Ray, 2011; Ray & Bratton, 2016).

Elementary school counselors who possess the appropriate training and credentials in play therapy may even more significantly benefit students. An increasing number of elementary school counselors account for the total number of mental health professionals who are trained in and utilize play therapy (Landreth, 2012). When provided as a responsive service within a comprehensive school counseling program (American School Counselor Association [ASCA], 2019; Ray, 2011), play therapy interventions provide elementary school counselors with a developmentally appropriate approach to supporting the learning potential and academic performance of students (McGuire, 2000). As school counseling programs are intended to provide for the needs of all students (White & Flynt, 1999), elementary school counselors must appropriately support the social, emotional, and academic needs of their students. In addition, school counselors are also the logical choice for collaboration with administrators, teachers, parents, and other stakeholders with a vested interest in a child's success in school (Sheely-Moore & Ceballos, 2015). The question then becomes not if the elementary school counselor uses play therapy but how school counselors will utilize play therapy in the elementary setting (Landreth, 2012). Moreover, research indicates that play therapy is effective in a diverse range of school settings due to its applicability with “a broad range of ages; with ethnically, culturally, and socially diverse populations; and with different structural formats” (Ray & Bratton, 2016, p. 70).

The following sections explore the existing literature on school counselors and play therapy. A total of 10 studies exist in the current literature that examine the training of school counselors in play therapy, the use of play therapy by school counselors, and specific approaches to play therapy used in the school setting by school counselors.

Training of School Counselors in Play Therapy

Since 2009, four unique studies have looked at play therapy training that has been provided specifically to school counselors (Anderson, 2022; Kagan & Landreth, 2009; Pereira & Smith-Adcock, 2013; Shin & Gonzalez, 2018). Of these four studies, one study was qualitative (Shin & Gonzalez, 2018). Shin and Gonzalez (2018) aimed to describe the experiences of elementary school counselors who participated in an introductory one-day, eight-hour workshop on child-centered play therapy. This study was conducted in light of the then-newly created School Based-Registered Play Therapist credential introduced by APT in 2016, reflecting the growing trend and need for using play therapy in the school setting by school counselors. Two research questions guided this study: first, what were the experiences of school counselors attending a play therapy workshop, and second, what are school counselors' perceptions regarding their use of play therapy in a school setting. After data was collected via three interviews with the six participants over a two-month period, two major themes emerged from this study: first, the participants' perception of play therapy changed. Specifically, participants reported having developed a greater awareness of child-centered techniques and play materials and a greater understanding of a child-centered philosophy. Second, the participants valued their experience in the one-day workshop because of the scope of the workshop's contents, the experiential learning activities provided during the workshop, and the atmosphere of collegiality co-created by attendees and facilitators.

The other three studies (Anderson, 2022; Kagan & Landreth, 2009; Pereira & Smith-Adcock, 2013) were quantitative. Anderson's (2022) study utilized Kao's (2009) Play Therapy Attitudes–Knowledge–Skills Survey (PTAKSS) to investigate the relationship between professional development and attitudes, knowledge, and skills in play therapy. While this study

did not focus solely on school counselors, a nonrandom sample of elementary school counselors and licensed professional counselors were surveyed in this study. Three of the four hypotheses in this study were confirmed: first, that counselors with university-level training had higher levels of attitudes, knowledge, and skills; knowledge in play therapy predicted the skill levels of the counselors; and APT membership related to higher levels of knowledge and skills in play therapy. A fourth hypothesis, that an increased number of hours in university training would predict higher attitudes, knowledge, and skills at a statistically significant level, was not supported. Kagan and Landreth's (2009) experimental study implemented a two-day CCPT workshop for Israeli school counselors and teachers. The workshop employed several different strategies for learning, including lectures, discussion, role playing, and observation of recorded clinical play therapy sessions. This study also utilized an older version of the PTAKSS (Kao & Landreth, 1997) and found significantly higher scores on the Knowledge subscale by those in the treatment, or instructional, group as compared to those in the control group who did not receive any play therapy instruction. Pereira & Smith Adcock's (2013) study similarly utilized Kao & Landreth's (1997) PTAKSS after holding a 12-hour CCPT workshop with 40 master's level school counseling students. This quasi-experimental design study also found an increase in self-reported knowledge, skills, and attitudes toward play therapy after receiving play therapy instruction, which included the history and theoretical background of CCPT, information on the culture of children and the eight basic principles of CCPT (Axline, 1947), skill development and practice with immediate instructor feedback, and case examples.

Use of Play Therapy by School Counselors

Three studies (Ray et al., 2005; Shen, 2016; Van Horne et al., 2018) look at the use of play therapy in the school setting by school counselors. Ray et al. (2005) surveyed 381 members

of the American School Counseling Association (ASCA) about their training in play therapy, use of play therapy, beliefs about play therapy, and limitations in using play therapy in the school setting. A survey was developed for this study based on Axline's (1947) underlying beliefs about children when implementing a child-centered therapeutic approach and McLeod's (2000) research regarding the use of play therapy in public schools. Results from the survey indicated a lack of training and lack of time available to work directly with students were the primary limitations revealed in this study, although elementary school counselors generally seemed to see the value in play therapy and indicated that they believe children have an inherent tendency towards maturity and growth, a central tenet to a child-centered approach to play therapy.

Shen (2016) conducted a study exploring the multicultural application of play therapy based on the experiences of school counselors. This study surveyed 86 school counselors in Texas who reported using play therapy as part of their comprehensive school counseling program. A survey was developed by the researcher based on current multicultural issues in play therapy literature and assessed for content validity by four experts in counselor education, play therapy, school counseling. The survey had also been tested in a pilot study of 27 school counselors to assess for school counselor demographic information and multicultural practices prior to use in this study. Research questions exploring school counselors' observations and experiences regarding students' diverse features, counselor-client cultural match, adaptations to play specifically related to the child's culture and ethnicity, and the relationship between school counselors' multicultural exposure and their observations and experiences in cultural groups' response to play therapy guided this study. Findings from the study demonstrated that students of most ethnic groups, with special needs, and of both genders tended to be more responsive to play therapy than other traditional language-based approaches to counseling alone. Additionally, there

was a statistically significant and positive relationship between counselors' exposure to designated cultural groups and counselors' observation of the groups' positive response to play versus talk therapy. The findings from the study also revealed that school counselors modified play techniques for students' special needs and play materials for both special needs and cultural contexts. The findings of this study support similar ideas presented by Ceballos et al. (2021) of play therapy as an intervention that can support efforts toward systemic change in schools in a way that is sensitive to cultural issues.

Van Horne et al. (2018) conducted a study that examined the variables relating to the use or nonuse of play therapy by elementary school counselors. The Elementary School Counselor Play Therapy Survey was developed for use in this study and consisted of 24 questions assessing for the respondent's age, race, gender, region of United States, setting, education and training in play therapy, hours per month they received play therapy supervision, quality of their supervision experience regarding play therapy, self-efficacy, and perceptions of their effectiveness using play therapy. A random sample of 2,500 elementary school counselor ASCA members were invited to participate in the survey. From the 192 respondents, only about one quarter reported having graduate coursework in play therapy. The major implications of this study's findings are the need to strengthen both the knowledge about play therapy and supervision experiences of elementary school counselors. Only 38 respondents reported receiving supervision of any kind, and only five indicated receiving current supervision in play therapy. The only statistically significant predictor of whether school counselors used play therapy was their perceived effectiveness using play therapy, and levels of self-efficacy and perceived effectiveness were inter-related.

Play Therapy Approaches Used by School Counselors

Two studies (Blanco et al., 2019; Shen, 2017) examined play therapy approaches being used in the school setting by school counselors. Blanco et al. (2019) examined if CCPT had an impact on the motivation and academic achievement of at-risk elementary-aged students. The researchers utilized the Early Achievement Composite of the Young Children's Achievement Test and the Academic Self-Regulation Questionnaire with participants in the treatment and control groups. The treatment group (n = 21) received eight weeks of biweekly, 30-minute play therapy sessions, while the waitlist control group (n = 21) received no services during the study. Children in the treatment group demonstrated a statistically significant increase on the Early Achievement Composite of the Young Children's Achievement Test when compared to children in the waitlist control group, while no significant differences were found between the two groups on the Academic Self-Regulation Questionnaire. Additional findings indicated that intrinsic motivation scores remained unchanged for the children in the treatment group, while those same scores declined for children in the waitlist control group. These results continue to support the use of CCPT as an intervention for academic achievement and as an important tool for school counselors to implement in a comprehensive school counseling program.

Shen's (2017) study was a qualitative study that explored the experiences of secondary school counselors using play therapy with their adolescent students. Ten counselors who work with secondary-aged students (6th-12th grade) were interviewed about their firsthand experiences in using play therapy with this age group. Research questions guiding Shen's (2017) study addressed how these counselors perceived the role of play in adolescent and lifespan development, what motivations drive secondary school counselors to utilize play therapy with their students, the adaptations counselors make when utilizing play with adolescents, the

theoretical approaches to play therapy secondary school counselors claim to use, and the obstacles secondary school counselors encounter when utilizing play therapy and how those obstacles are overcome. Themes that emerged from the interviews that contributed to the use of play therapy with this age group included affirmation of the value of play during adolescence and throughout the lifespan, confirmation that play is often utilized to help adolescents relax and open-up in a therapeutic setting, and positive core values driving play therapy usage. Other themes identified that might hinder the use of play therapy included resource constraints including budget, play space, and time; insufficient theoretical foundation; and mixed views about the use of video gaming as an approach to play therapy. Shen (2017) posited that these issues likely warrant further research if the use of play therapy is to be advanced in the secondary school setting.

Literature Gaps

While there are additional studies exploring the use of play therapy with elementary-aged children within the school setting, most of these studies utilize outside mental health providers as the play therapist, not the school counselor. It is unclear whether the lack of available literature in this area is due to the absence of training in play therapy for school counselors, if elementary school counselors do not see the value in or benefit of play therapy, if there are time- or cost-associated barriers to utilizing play therapy in the school setting, or other unknown factors. In conjunction with the paucity of literature on school counselors and their use or perceptions of play therapy, only one study (Ray et al., 2005) assessed the relationship between school counselors' beliefs about play therapy and the use of play therapy in the schools. Like Hindman's (2020) study, Ray et al. (2005) developed a survey to assess for this information. It is reasonable to assume that not only may elementary school counselors have differing beliefs or

attitudes about play therapy than they did nearly 20 years ago, but that a more recently-developed survey may provide greater insight and account for issues in the field of play therapy that may not have been as prominent prior to the last couple of decades. Van Horne et al. (2018) also developed a survey and explored the variables contributing to the use or nonuse of play therapy by elementary school counselors, including perceived effectiveness, but did not expose respondents to information about play therapy to assess whether that could impact utility perception. The current study explored both utility perception with a newly developed survey and whether brief information could impact those perceptions. The following chapter will detail the methodology that was used in the current study.

Chapter 3 - Methodology

This chapter provides an overview of the current study's methodology and procedures of the study. This chapter includes (a) research questions; (b) measure; (c) participants; (d) study design; (e) procedures and data collection; and (f) analysis approach.

The purpose of the current study was to learn about elementary school counselors' perceptions of the utility of play therapy and if providing information about play therapy changed these perceptions. An instrument known as the Play Therapy Utility Instrument, which was used in one previous study (Hindman 2020; Hindman et al., 2022), was used to measure elementary school counselors' beliefs about the efficacy of play therapy in facilitating mental wellness and health in children.

Research Questions

The following questions were addressed by this study:

1. What is the initial perception of play therapy by elementary school counselors?
2. Does this initial perception vary based on three background variables: community classification, Title I status, and training in play therapy?
3. Does exposure to information about play therapy significantly change elementary school counselors' perceived utility of play therapy services?
4. If there is a change in perception, does this vary based on three background variables: community classification, Title I status, and training in play therapy?

Measure

Prior to research conducted by Hindman (2020), there was not a measure in the literature that assessed for adult perceptions of the utility of play therapy. The current study utilized the instrument initially developed for the aforementioned study (Hindman, 2020; Hindman et al.,

2022). This instrument, known as the Play Therapy Utility Instrument, is a 14-item self-report questionnaire that measures respondents' perceptions of what situations play therapy can be used to facilitate growth and attitudes regarding the developmental appropriateness of play therapy for children on a 5-point Likert scale: (1) *strongly disagree*, (2) *disagree*, (3) *neutral*, (4) *agree*, (5) *strongly agree*. Survey respondents rate the degree to which they believe play therapy to be a developmentally appropriate approach to aid in the development of children's social, emotional, cognitive, and behavioral competencies (Hindman, 2020). Lower scores indicate a perception of low utility of play therapy, and higher scores indicate a perception of a high utility of play therapy. The instrument can be viewed in Appendix E.

Hindman (2020) found three questions from the survey to be invalid and eliminated them from the data analysis due to having factor loadings less than .4. Internal consistency reliability of the instrument was analyzed with all 14 items, which produced a moderately strong internal consistency reliability of .80. Once the three questions with factor loadings less than .4 were removed from the survey, the internal consistency reliability level proved to be stronger with a Cronbach's alpha value over .87. While the Kaiser Criterion detected two eigenvalues greater than 1.0, indicating a 2-factor model, Hindman (2020) found that Cattell's scree plot method indicated a 1-factor model, which ultimately was what was used. In both pre- and post-information analyses, items loaded moderately well after the removal of the three survey questions with factor loadings less than .4. In the current study, this researcher considered that it could be beneficial to retain these three questions, considering the novelty of the instrument as well as the fact that this study targeted a different population (school counselors) than the original study (general adult public). For these reasons, the current study did not eliminate these

three questions from the survey. An examination of the structure of the instrument and a reliability check was conducted and is addressed in chapter four.

Five self-report background questions included in the survey asked participants to report their highest degree earned, age group served in current employment setting, community classification of school population served, Title I status, and self-reported training in play therapy. To ensure that participants have received the education and training this study presumed them to have received, respondents were asked to indicate their highest earned degree in counseling: master's, education specialist, or doctorate. Two additional response options for level of education included an option for school counselors working under a provisional, or temporary, license, and an "other" option, allowing respondents to explain their education and certification status if one of the other four options did not accurately represent their level of education. Survey participants were then asked what level best represented the setting in which they were employed as a school counselor: elementary, middle, high, or K-12. Respondents who indicated that they were employed at the middle or high school levels were eliminated from the results. Survey participants were then asked if the community classification of their setting of employment would be considered urban, suburban, or rural. Respondents also reported if they worked in a building that qualified for Title I funding. Title I schools are schools in which children from low-income families make up at least 40 percent of enrollment (U.S. Department of Education, 2018). Following these questions, respondents were asked if they had any prior formal training in play therapy procedures. Respondents who answered "yes" were asked an additional question about their level of expertise in play therapy. The response options to this question were: (1) *I took a required or elective credit-hour course in play therapy during my graduate program and have not pursued any additional training*, (2) *I have received some post-*

graduate training (workshops, webinars, credit-hour courses, etc.) in play therapy, but was not offered a required or elective credit-hour course in play therapy during my graduate program, (3) I have received training in play therapy through a combination of required or elective graduate-level coursework and post-graduate trainings (workshops, webinars, credit-hour courses, etc.), (4) I have received training in play therapy and am currently under supervision for an RPT or SB-RPT credential, and (5) I hold/held an active credential from the Association for Play Therapy (RPT, SB-RPT, or RPT-S).

Participants

Participants were a convenience sample of 191 of practicing elementary school counselors in the United States who held a master's degree or higher in counseling or a related field. Participants were recruited through ASCA Scene, a forum community for ASCA members; the Missouri School Counselor Association [MSCA]'s Monday Memo, a weekly email newsletter sent out to MSCA members; and through personal email communication with the researcher. Participation was entirely voluntary, all survey questions were optional to answer, and no compensation was provided for survey completion.

Study Design

The current study is an exploratory study that utilized a one-group pretest-posttest design (Johnson & Christiansen, 2020). Survey respondents answered questions about their perceptions of the utility of play therapy from the Play Therapy Utility Instrument (Hindman, 2020; Hindman et al., 2022), watched a 1:25 minute informational video about play therapy, then answered the questions from the Play Therapy Utility Instrument again. The informational video about play therapy that participants watched served as this study's treatment, as the video was viewed immediately after participants answered the 14 questions of the Play Therapy Utility

Instrument, and immediately before they answered these same 14 questions again. The best fit for collecting data for this study was a survey design; however, due to the nature of the study, no comparison group is used. Without a control group, the internal validity is limited, and caution should be taken when assuming cause and effect (Johnson & Christiansen, 2020). Participants accessed and completed the survey through Qualtrics online survey software. For the purposes of determining response quality, a control question, “What drink was mentioned in the video?” was inserted into the survey. Any participant’s data that did not have the correct answer to this control question was eliminated from the dataset. Conducting an online survey was beneficial as it allowed for convenient access for participants to respond, was cost-effective, and data were available directly after completion.

Procedures and Data Collection

Prior to conducting this study, this researcher obtained exemption status from Kansas State University’s Institutional Review Board (IRB) (See Appendix A for IRB approval letter). After IRB approval was secured, participants were recruited in a variety of ways. The researcher, who was also an elementary school counselor at the time this study was conducted, sent the survey out via a Qualtrics link to her elementary school counselor colleagues in multiple school districts and encouraged the survey to be passed on to their colleagues. The survey link was also posted on ASCA Scene discussion boards and sent out to school counselors in the state of Missouri by the state’s professional school counseling organization as part of their weekly newsletter. The survey link opened on April 25, 2022 and was active for four weeks. After 12 days, a reminder email was sent to personal acquaintances of the researcher and the link was re-posted on the ASCA Scene discussion board 10 days and 15 days after the initial recruitment post. The link was included in the MSCA bi-weekly newsletter on May 9, 2022. No incentives

were given for participation in this study, and study participation was entirely voluntary, as was explicitly stated in all communication affiliated with the study. No identifying information was gathered as part of this study, and individual responses could not be affiliated with any specific participant. In addition to these measures, the researcher also conducted herself in accordance with the American Counselor Association (ACA)'s Code of Ethics (2014) and the American School Counselor Association (ASCA)'s Ethical Standards for School Counselors (2016).

Participants were provided with a Qualtrics link that provided them with informed consent for the study and self-report background questions including highest degree earned, age group served in current employment setting, community classification of school population served, Title I status, and self-reported training in play therapy. After these preliminary items were answered, respondents answered questions pertaining to mental health and play therapy services, watched a 1:25 minute informational video about play therapy and its benefit in helping children express their thoughts and feelings, then responded to the same questions pertaining to mental health and play therapy services. These questions were a Likert scale instrument. For the purposes of controlling for response quality, a control question ("What drink was mentioned in the video?") was inserted into the survey immediately following the video.

Collected data were analyzed using IBM SPSS Statistics (Version 28.0.1.0) predictive analytic software to determine the relationships between variables related to the research purpose. As this project consisted of anonymous self-report data, the risk of harm was no greater than what would normally be present in everyday computer use. In case a participant was troubled by the study, the National Alliance on Mental Illness (NAMI) crisis service helpline phone number and hours of operation, the NAMI crisis after-hours text line, and the NAMI (2019) website for more information were listed at the completion of the survey.

Analysis Approach

Preliminary analyses were conducted prior to conducting primary analyses on the data in relation to the research questions. Descriptive statistics were assessed as part of the preliminary analyses prior to conducting the primary analyses. The internal consistency reliability analyses were also conducted on Play Therapy Utility Instrument to examine the structure of the instrument. For RQ1, a confidence interval and descriptive data was used to estimate the average initial perception of play therapy by the study participants. For RQ2, a between-subjects analysis of variance (ANOVA) was used to examine whether this perception varies based on population served and self-reported training in play therapy. For RQ3, a paired-sample *t*-test was used on pre-post comparison based on exposure to the informational play therapy video, given that all statistical assumptions are met. For RQ4, a between-subjects ANOVA was used to examine whether this change varies based on population served and self-reported training in play therapy. In the following chapter, the results of data gathered in this study are presented.

Chapter 4 - Results

The purpose of this study was to explore the perception school counselors have about the utility of play therapy, whether exposure to brief information about play therapy has an impact on school counselors' perceptions, and the potential effect that previous training in play therapy may have on their perception of its utility.

The following research questions (RQs) were addressed by this study:

1. What is the initial perception of play therapy by elementary school counselors?
2. Does this initial perception vary based on three background variables: community classification, Title I status, and training in play therapy?
3. Does exposure to information about play therapy significantly change elementary school counselors' perceived utility of play therapy services?
4. If there is a change in perception, does this vary based on three background variables: community classification, Title I status, and training in play therapy?

For RQ1, a confidence interval and descriptive data was used to estimate the average initial perception of play therapy utility by the study participants. For RQ2, a between-subjects analysis of variance test (ANOVA) was used to examine whether this perception varies based on population served and self-reported training in play therapy. For RQ3, a paired-sample t-test was used on pre-post comparison based on exposure to the informational play therapy video. For RQ4, a between-subjects ANOVA was used to examine whether this change varies based on population served and self-reported training in play therapy.

Participants

Participants were a convenience sample of practicing elementary school counselors in the United States who held a master's degree or higher in counseling or a related field. Participants

were recruited through ASCA Scene, a forum community for ASCA members; the MSCA's Monday Memo, a weekly email newsletter sent out to MSCA members; and through personal email communication with the researcher. Participation was entirely voluntary, and no compensation was provided for survey completion

The survey recorded 216 responses. Of these 216 responses, 19 were found to be incomplete and were eliminated from the data set. Four respondents reported that they were not elementary counselors, and those responses were also eliminated from the data set. Finally, a control question ("What drink was mentioned in the video?") was utilized to ensure respondents had watched the video that served as the treatment for this study. Of the remaining 193 respondents, 191 correctly answered the control question. These 191 responses were retained as the sample and utilized for the purposes of data analysis for this study.

Demographic Data

Descriptive statistics for the demographics of participants is listed in the tables below. Survey respondents were asked to provide demographic information about their gender, race/ethnicity, highest degree earned in counseling or a related mental health field, grade level served as a school counselor, community classification of employment setting, Title I funding status, and prior training in play therapy. Respondents who indicated receiving prior training in play therapy were asked an additional question about the extent of their play therapy training and/or certification.

A majority of the respondents reported themselves as female (93.2%, Table 4.1), described their ethnicity as White (92.7%, Table 4.2), had received a master's degree as their highest earned degree in counseling (83.9%, Table 4.3), worked in a suburban setting (56.5%,

Table 4.4), received Title I funding (58.1%, Table 4.5), and had received some form of play therapy training (52.9%, Table 4.6).

Table 4.1

Sample Demographic: Gender

Gender	Frequency	Percent
Male	13	6.8
Female	178	93.2
Non-binary/Third gender	0	0
Prefer to self-describe	0	0

Table 4.2

Sample Demographic: Race and Ethnicity

Race/Ethnicity	Frequency	Percent
American Indian or Alaska Native	1	0.5
Asian	1	0.5
Black	10	5.2
Hispanic or Latino	3	1.6
Native Hawaiian or Other Pacific Islander	0	0
White	177	92.7

Two participants reported being currently employed as an elementary school counselor under a provisional (temporary) license while completing their master’s degree in counseling. The most common requirement for provisional licensure set forth by state boards of education require a candidate to have completed at least 50% of the coursework towards a degree. Additionally, both respondents contacted the author of this study by email asking if they would qualify to take this study’s survey due to their provisional licensure status. One respondent indicated being in their practicum semester, which is most commonly completed about two semesters before graduation, and the other respondent indicated a graduation date of less than 30 days from the date of their email. Given these details, these responses were retained as part of the sample. The six respondents who replied “other” provided write-in information indicating that, at

minimum, they must have earned a master’s degree in counseling or a related mental health field. Examples of provided write-in information included “LPC” (licensed professional counselor), “National Board-Certified School Counselor,” “M.Ed. plus 30,” indicating an additional 30 or more continuing education hours that may or may not be applied to an advanced (education specialist, doctorate) degree, “RPT” (Registered Play Therapist), and “LCSW” (licensed clinical social worker). Given the nature of the provided additional information, these responses were also retained as part of the sample.

Table 4.3

Sample Demographic: Highest Degree Completed in Counseling or Other Mental-Health

Related Field

Level of Education	Frequency	Percent
Masters	160	83.9
Education Specialist	14	7.3
Doctorate	9	4.7
Provisional Licensure	2	1
Other	6	3.1

Respondents who indicated working with a K-12 school population were retained as part of this study’s sample due to serving elementary-aged students as a school counselor in addition to secondary-aged students. Three respondents who reported working at the middle school level and one respondent who reported working at the high school level were eliminated from the sample.

Table 4.4

Sample Demographic: Grade Level Served as School Counselor

Level Served	Frequency	Percent
Elementary	185	96.9
K-12	6	3.1

Table 4.5*Sample Demographic: Community Classification of Employment Setting*

Community Classification	Frequency	Percent
Urban	50	26.2
Suburban	108	56.5
Rural	33	17.3

Table 4.6*Sample Demographic: Title I Funding Status of Employment Setting*

Title I Funding	Frequency	Percent
Yes	111	58.1
No	65	34
Unsure/Prefer not to say	15	7.9

Table 4.7*Sample Demographic: Prior Training in Play Therapy*

Prior Play Therapy Training	Frequency	Percent
Yes	101	52.9
No	90	47.1

The 101 survey participants who responded that they had received prior training in play therapy were asked an additional question about the kind of training and/or certification in play therapy (see Table 4.8). Only one of these 101 participants did not provide information about their play therapy training experiences.

Table 4.8*Sample Demographic: Level of Training and/or Certification in Play Therapy*

Type of Play Therapy Training	Frequency	Percent
I took a required or elective credit-hour course in play therapy during my graduate program and have not pursued any additional training.	16	15.8
I have received some post-graduate training (workshops, webinars, etc.) in play therapy, but was not offered a required or elective credit-hour course in play therapy during my graduate program.	34	33.7
I have received training in play therapy through a combination of required or elective graduate-level coursework and post-graduate trainings (workshops, webinars, credit-hour courses, etc.).	29	28.7
I have received training in play therapy and am currently under supervision for an RPT or SB-RPT credential.	12	11.9
I hold/held an active credential from the Association for Play Therapy (RPT, SB-RPT, or RPT-S).	9	8.9

Reliability

Internal consistency reliability was measured using Cronbach’s alpha for the Play Therapy Utility Instrument. SPSS excluded one response due to missing data, leaving 190 responses verified for reliability. Items 3 and 6 were reverse coded due to the negative modifiers in the written question (i.e., “Play therapy is not useful for children 3 to 12 years old”) or inaccurate information provided within the question (i.e., “Children mostly talk to understand their world”). Hindman (2020) found three questions from the survey to be invalid and eliminated them from the data analysis due to having factor loadings less than .4. Preliminary analyses were conducted with all 14 items and after removing the same three items (questions 3, 6, and 13) removed in Hindman’s (2020) study. The current study produced similar internal

consistency reliability results both with all 14 items and when removing the same three items that were removed in Hindman’s (2020) study. With all 14 items, the internal consistency reliability level was moderately strong for the instrument with values just below .80 for both pre- and post-information about play therapy. When items 3, 6, and 13 were removed, the internal consistency reliability level was strong, rising to nearly .89 (Table 4.9).

Table 4.9
Reliability and SEM for the Play Therapy Utility Instrument.

Timing	Number of items	N	M	SD	Min.	Max.	Cronbach’s alpha	SEM
Pre-information	14	190	4.396	.374	3.500	5.000	.802	.027
Post-information	14	190	4.394	.393	3.500	5.000	.799	.029
Pre-information	11	190	4.462	.400	3.364	5.000	.848	.029
Post-information	11	190	4.501	.416	3.454	5.000	.889	.030

Assumptions and Analytic Results

The statistical assumptions and findings for the principal analyses are addressed with regard to each research question (RQ). Analyses were conducted using the 11 retained survey items. IBM SPSS Statistics (Version 28.0.1.0) predictive analytic software was used to conduct all statistical analyses.

RQ1: What is the initial perception of play therapy by elementary school counselors?

For confidence interval estimations to be held, a population mean must meet inferential procedure assumptions of having random sampling of the data and either normality or a large sample size. For RQ1, normality was measured with the Shapiro-Wilk test. Given the relatively large sample size (i.e., > 30), all assumptions for confidence interval estimation were tenable.

Data was collected to assess how elementary school counselors perceived play therapy. When participants were asked after viewing information about play therapy how likely they were to recommend play therapy services in the future, 166 (86.8%) said very likely, 24 (12.6%) said somewhat likely, and 1 (0.6%) said neither likely nor unlikely. No respondents reported they were somewhat unlikely or very unlikely to recommend play therapy services in the future. Additionally, respondents were asked how likely they were to pursue training and/or credentialing in play therapy in the future, 102 (53.4%) said very likely, 63 (32.9%) said somewhat likely, 15 (7.9%) said neither likely nor unlikely, 10 (5.2%) said somewhat unlikely, and 1 (0.6%) said very unlikely. Even before viewing the informational video about play therapy, elementary school counselors appeared to view play therapy as useful. The initial perception of the utility of play therapy is $M = 4.462$, $SD = .399$, 95% CI [4.405, 4.519], with skewness of $-.290$ and kurtosis of $-.943$. The Shapiro-Wilk test indicated that the data are not normally distributed, $p < .001$.

RQ2: Does this initial perception vary based on three background variables: community classification, Title I status, and self-reported training in play therapy?

Like RQ1, the observed pre-information data was analyzed for RQ2. Assumptions of the between-subjects ANOVA are independence of the data, normality, and homogeneity of variance. Independence was supported through the sampling method as each participant took the survey only once. Normality of the pre-information mean was violated ($p < .001$), and the pre-information scores were not normally distributed. Levene's test was conducted to test homogeneity of variance. For the community classification variable, Levene's test was not statistically significant, $p = .659$, indicating we would assume that variances are homogenous across the three community classification categories (urban, suburban, and rural). Levene's test

was also conducted to test homogeneity of variance among respondents who reported their building's Title I funding status. Levene's test was not statistically significant, $p = .135$, indicating that the variances are homogenous among the three funding response categories (yes, no, unsure/prefer not to say). Finally, Levene's test was conducted to test homogeneity of variance between respondents who reported having received prior training in play therapy and respondents who reported having no prior training in play therapy. Levene's test was not statistically significant, $p = .513$, indicating that the variances are homogenous between the two training categories.

With a data set that has violated the assumptions of normal distribution, some researchers may choose to conduct a non-parametric test on the data, such as a Kruskal Wallis test. However, ANOVA is considered a robust test against the normality assumption. In other words, a one-way ANOVA can tolerate data that have skewed or kurtotic distributions with only a small effect on the Type I error rate. Because of this, a one-way between-subjects ANOVA was initially conducted to test for any significant differences in initial perception of play therapy utility based on the community classification variable of where an elementary school counselor was employed (urban, suburban, or rural). The F test was not statistically significant, $F(2, 188) = .42, p = .659$. A Kruskal Wallis test was also conducted to test for any remarkable differences between the two test results. The H test also produced a non-significant result, $H(2) = 1.07, p = .586$.

A one-way between-subjects ANOVA was also conducted to test for significant differences in initial perception of play therapy utility based on the Title I funding status of the building where the respondent was employed. The F test was not statistically significant, $F(2, 188) = .38, p = .685$. A Kruskal Wallis test was also conducted to test for any remarkable

differences between the two test results. The H test also produced a non-significant result, $H(2) = .94, p = .624$.

Finally, a one-way between-subjects ANOVA was also conducted to test for any significant differences in initial perception of play therapy utility based on whether the respondent had received any prior training in play therapy. The F test was statistically significant with respondents who had received prior training in play therapy perceiving play therapy more favorably, $F(1, 189) = 16.52, p < .001$. A Kruskal Wallis test was also conducted to test for any remarkable differences between the two test results. The H test was also statistically significant, $H(1) = 16.21, p < .001$.

RQ3: Does exposure to information about play therapy significantly change elementary school counselors' perceived utility of play therapy services?

The assumptions for a paired-samples *t*-test include that the two groups of data are paired, there are no significant outliers, and there is normality of the paired differences. The data set meets the assumption of paired data as the same person completed the Play Therapy Utility Instrument pre- and post-information. The Shapiro-Wilks test of normality was violated, $p < .05$, indicating that this sample is not normally distributed.

Because the data are not normally distributed, a Wilcoxon Signed-Rank Test was conducted to investigate whether the pre-information and post-information mean scores differed significantly. This is a non-parametric test that does not require any assumptions about the shape of the distribution, making it beneficial to run with this study's non-normally distributed data set. The Wilcoxon Signed-Rank Test demonstrated post scores statistically significantly higher than the pre scores, $Z = 2.28, p = .023$.

RQ4: If there is a change in perception, does this vary based on three background variables: community classification, Title I status, and self-reported training in play therapy?

Like RQ2, a between-subjects ANOVA and a Kruskal Wallis test were conducted for RQ4. Normality of the post-information mean was violated with $p < .001$, indicating that the post-information scores were also not normally distributed. For the community classification variable, Levene's test was not statistically significant, $p = .525$, indicating we would assume that variances are homogenous across the three community classification categories (urban, suburban, and rural). Levene's test was also not statistically significant, $p = .487$, in post-information responses for the Title I funding status variable, nor was it statistically significant, $p = .146$, in post-information responses between participants who reported having received prior training in play therapy and participants who reported having no prior training in play therapy.

A one-way between-subjects ANOVA was conducted to test any significant changes in the perception of play therapy utility based on the community classification variable of where an elementary school counselor was employed (urban, suburban, or rural) after participants had viewed information about play therapy. The F test was not statistically significant, $F(2, 187) = .24, p = .791$. A Kruskal Wallis test was also conducted with the same data, and the H test also produced a non-significant result, $H(2) = .85, p = .654$.

A one-way between-subjects ANOVA was also conducted to test for any significant changes in the perception of play therapy utility based on the Title I funding status of the building where the respondent was employed. The F test was not statistically significant, $F(2, 187) = .41, p = .662$. A Kruskal Wallis test was conducted with the same data, and the H test also produced a non-significant result, $H(2) = .92, p = .631$.

A one-way between-subjects ANOVA was also conducted to test for any significant changes in the perception of play therapy utility based on whether the respondent had received any prior training in play therapy. The F test was statistically significant, showing respondents who had received prior training in play therapy perceiving play therapy more favorably, $F(1, 188) = 12.34, p < .001$. A Kruskal Wallis test conducted with the same data also produced statistically significant results, $H(1) = 11.30, p < .001$.

Summary

This chapter presented the results of the current exploratory study including demographic data of the study sample, reliability data of the survey instrument, and statistical assumptions and analyses for this study's four research questions. Results indicated that participants initially perceived play therapy as useful. While there was not a significant difference in the initial perceptions of play therapy among elementary school counselors based on the community classification where they're employed, there was a significant difference in initial perceptions between the groups who did and did not have prior training in play therapy or not, with a higher overall mean score from participants who reported having prior training in play therapy. Overall, there was a statistically significant difference in elementary school counselors' perceived utility of play therapy services after being exposed to brief information about play therapy. This change in perception was not significantly impacted based on the community classification where participants were employed, but there was statistical significance based on participants' play therapy training status, with a higher overall mean score from participants who reported having prior training in play therapy. Chapter five provides a discussion about the current study, including findings, implications of the data, limitations of this study, and recommendations for future research.

Chapter 5 - Discussion

The previous chapter presented and analyzed the results of the current study. This concluding chapter presents a summary of the study's findings, implications of the study's results, limitations of the current study, and recommendations for future research and practice.

Summary of the Findings

Play therapy is a valuable approach that all mental health professionals, including school counselors, can use as they serve children. At odds with the use of play therapy by school counselors is the paucity of published studies related to both play therapy and school counselors. The bulk of the research that had been conducted at the intersection of these two subjects looked primarily at providing specific training in play therapy to school counselors (Anderson, 2022; Kagan & Landreth, 2009; Pereira & Smith-Adcock, 2013; Shin & Gonzalez, 2018), the general use or nonuse of play therapy by school counselors (Ray et al., 2005; Shen, 2016; Van Horne et al., 2018), and the specific play therapy approaches used by school counselors (Blanco et al., 2019; Shen, 2017).

The purpose of the current study was to learn about elementary school counselors' perceptions of the utility of play therapy and if providing information about play therapy changed these perceptions. Although play therapy has been demonstrated to be effective in treating commonly occurring mental and behavioral health needs of children (Anderson & Gedo, 2013; Chen et al., 2021; Haas & Ray, 2020; Hateli, 2022; Li et al., 2016; Patterson et al., 2018; Smithee et al., 2021; Wilson & Ray, 2018) and supporting the academic achievement of elementary students (Perryman et al., 2020; Winburn et al., 2017), there is a very limited understanding of school counselors' knowledge of and training in play therapy. Since school counselors are in a unique position to support the mental health needs of their student population,

which in turn helps to maximize the academic achievement of their students (ASCA, n.d.), it seemed beneficial to investigate their knowledge and perceptions on this topic.

This exploratory study utilized a one-group pretest-posttest design and consisted of a sample of 191 school counselors who work with elementary-aged students. These participants voluntarily completed the Play Therapy Utility Instrument before and after they received information in the form of a short, educational video about play therapy. Results were mixed regarding statistical significance.

The first research question explored the initial perceptions elementary school counselors had of play therapy utility, which produced data that suggest that elementary school counselors view play therapy as useful. The current findings were consistent with the findings in Hindman's (2020) study that used the same instrument to survey the general adult public about their perceptions of play therapy utility and similar to findings from Ray et al. (2005) that indicated elementary school counselors have a positive impression of the use of play therapy.

The second research question investigated whether initial perceptions varied based on the kind of population an elementary school counselor served, including the community classification variable and low-income status variable, and whether the respondent had or had not received prior training in play therapy. Data produced non-statistically significant results when comparing the initial perceptions among the community classification where the elementary school counselor reported working (urban, suburban, or rural) and the initial perceptions based on Title 1 funding status of their building of employment. However, statistical significance was detected in the initial perceptions of the utility of play therapy based on whether a respondent reported having or not having prior training in play therapy.

The third research question examined whether exposing elementary school counselors to information about play therapy resulted in a significant change in perception of its utility. Like Hindman's (2020) study, which found an increase in scores after participants had received information about play therapy, the overall perception of play therapy utility demonstrated a statistically significant increase from pre-information to post-information scores.

The fourth research question evaluated whether any significant changes in perception were impacted by population served or status of prior training in play therapy. Similar to this study's second research question, the data suggest that neither the community classification nor the Title I funding status of where an elementary school counselor works are key factors in participants' changes in perception of play therapy utility, as both of these produced non-statistically significant results. However, statistical significance was detected between the pre- and post-information scores of respondents based on their prior play therapy training status.

Implications

The findings from this study may have several implications for providing education and training in play therapy for elementary school counselors. The data from this study suggest that even an approximately one-and-a-half-minute video on play therapy can influence elementary school counselors' perceptions of play therapy utility. Moreover, as the inclusion criteria to participate in this study was somewhat restrictive, it is noteworthy that 216 school counselors participated in this survey in a relatively short period of time. This suggests that play therapy may be an important or interesting topic to school counselors.

Findings from this study suggest that elementary school counselors already saw play therapy as valuable, even before they were provided with brief educational information about it. It is reasonable to assume that those who reported having prior training in play therapy would

have a more favorable view of it, but only 52.9% of this study's respondents had any kind of prior play therapy training. However, the analyses suggest that the entire sample seemed to initially view play therapy as very useful. This may be due to the understanding elementary school counselors have about the developmental norms of the age group with which they work, as most professionals who work with young children seem to hold the belief that play is valuable for children. It is also possible that a school counselor who has no training in play therapy may know a play therapist as part of their professional network of peers, which could positively influence their perceptions of or knowledge about play therapy. No survey respondents indicated that they were "somewhat unlikely" or "very unlikely" to recommend play therapy services in the future, further suggesting the positive regard elementary school counselors have of play therapy. Furthermore, this positive regard for play therapy was irrespective of their prior knowledge of and training in play therapy or their reported intentions of pursuing play therapy training or credentialing in the future.

The data from this study also suggested that the location where an elementary school counselor is employed and whether an elementary school counselor works with a low-income population has little bearing on their overall perceptions of play therapy. However, the reported prior play therapy training status of a respondent did seem to be a key factor in their perceptions of play therapy. These findings may have a couple of implications. First, there may be a perception that elementary school counselors who work in communities with a greater number of available mental health providers or in towns where a university or other organization has a play therapy training program may have a more favorable view of play therapy. While these questions were not asked of respondents explicitly, it is reasonable to presume that this study's respondents had a variety of exposure to play therapy based on questions they were asked. In short, neither

where an elementary school counselor works nor the low-income status of the building where they are employed seem to have any remarkable impact on their perception of play therapy. Second, the significant differences in the perception of play therapy utility between respondents who have received play therapy training and respondents who have not makes logical sense. It was reasonable to assume that individuals who had prior training in play therapy would have a more favorable view of it. Similarly, Hindman (2020) found that members of the adult public who had higher levels of confidence in their understanding of play therapy also found it to be more useful initially. Elementary school counselors who have received training in play therapy likely have a greater understanding of play therapy than their colleagues who have not received play therapy training, making these findings consistent with Hindman's (2020) study.

Finally, it is noteworthy that there were statistically significant differences detected between overall pre-information and post-information scores with a population that already had a robust understanding of mental health and a favorable view of play therapy. Moreover, this significant change was detected after participants viewed a very brief informational video about play therapy. This seems to suggest that a very brief, basic illustration and explanation of play therapy is able to positively influence a person's view of it. Hindman (2020) also found a statistically significant difference between pre and post scores using the same video and same instrument; however, her study was conducted with the general adult public. The current study found similar results, even though the population identified for this study had extensive training in mental health and working with children. Given this information, it may be worth considering how counselor preparation programs should train their students who plan to work therapeutically with minors. No one graduate program can prepare a pre-service counselor for everything they will encounter during their career. However, it could be beneficial to consider the provision

foundational coursework in play therapy as part of a master's-level counseling or school counseling program. This could provide an integration of instruction in developmental theory and skills practice in a format that allows the learning of play therapy skills and techniques, an effective intervention for children ages three to 12 years old.

Limitations

There are some limitations to this study, and the results should be interpreted with caution and regarded as suggestive. First, this study used a convenience sample and the demographic makeup of the sample was not representative of the member demographics reported by ASCA (2020a). However, it is similar to the demographics of practicing school counselors in Missouri and other Midwestern states, an area from which the majority of this sample was recruited. Nevertheless, this likely makes the findings of this study difficult to generalize to the entire population of elementary school counselors. Research with a more varied demographic sample is recommended.

Another limitation was the self-report nature of this study. Individuals are often biased when reporting on their own experiences or level of knowledge, which can lead to method bias in the response tendencies a participant may apply throughout the survey (Podsakoff et al., 2012). This means respondents may answer questions in a way that is perceived to be more socially acceptable or more congruent with their beliefs about what they should know about a given topic. While this study took measures to limit this type of bias – such as voluntary participation and confidentiality and anonymity of responses – and all questions were presumed to be answered honestly by participants, there is always a risk of inaccurate self-assessment or misinterpretation of survey questions, which is difficult to control. Because of this, results should be interpreted with caution.

An additional limitation was the lack of a control group, which limits the internal validity of the study (Johnson & Christiansen, 2020). A control group allows an observer to draw the conclusion that any changes observed in a treatment group are reasonably presumed to be due to the treatment or intervention experienced by the treatment group and not due to other known or unknown factors. Caution should be taken when assuming cause and effect in this study due to its design.

A final limitation of this study is the use of a survey that was newly created and under development. The Play Therapy Utility Instrument was designed for Hindman's (2020) dissertation study after no instruments that measure an adult's perceptions of play therapy utility were found in the existing literature. To date, this is only the second study to utilize this survey for research purposes. Although similar findings were discovered in this study and in Hindman's (2020) study regarding instrument reliability, this survey should still be regarded as more of a questionnaire than a standardized instrument. Further study and development of the Play Therapy Utility Instrument is recommended.

Recommendations for Research

While research is limited in both general perceptions of play therapy utility and school counselors' perceptions of play therapy, prior research on the topic has relied on the development of an instrument or survey specifically for the study (Hindman, 2020; Ray et al., 2005; Van Horne et al., 2018). It may be beneficial for similar future research to utilize the Play Therapy Utility Instrument in conjunction with another instrument. Including multiple instruments in the evaluation material could provide data to compare convergently against data gathered from the Play Therapy Utility Instrument, which could offer additional data related to its reliability and aid in this instrument's continued development.

The literature would also benefit from additional research on the specific barriers school counselors experience in receiving training in play therapy. This could illuminate practical issues in obtaining play therapy training and offer suggestions for future practice. It could also be beneficial to research the barriers a school counselor who is trained in play therapy experiences in incorporating play therapy services as part of their comprehensive school counseling program.

A qualitative or mixed methods approach to this study could help to provide greater depth of insight into elementary school counselors' perceptions of play therapy utility. The data from the current study suggest elementary school counselors already held a favorable view of play therapy before receiving any additional information about it. A qualitative study could bring to light the reasons why elementary school counselors believe play therapy is beneficial, or how they developed that opinion, particularly in cases of school counselors who report not having received any kind of prior training in play therapy. It may also be beneficial to expand the inclusion criteria to include school counselors who work with older students, as several approaches to play therapy are easily and often adapted to work with older students or clients.

A study similar to the current study could be conducted utilizing a control group and modifying how elementary school counselors receive information about play therapy. While the current study utilized a brief informational video, future research could offer a class or weekend workshop on play therapy to some participants, while other participants are part of a waitlist group that could receive the same training at the conclusion of the study. The Play Therapy Utility Inventory could be administered pre- and post-training for both treatment and control groups to explore the impact of a training experience on perceptions of play therapy utility. This would also provide additional data on this study's instrument and its use with a different informational and research format.

Modifying the amount of elapsed time between the pre-test and post-test would also benefit the existing literature on play therapy. This study's sample was highly educated, and an argument could be made that the respondents in this study could have reasonably presumed that the researcher was looking for an increase in scores by asking the same questions immediately after providing participants with information on play therapy. Future studies may want to delay the gathering of post-information scores in order to explore whether any kind of exposure to information about play therapy has any long-term effect on a participant's perception of it.

Future research could also look at the practicalities, benefits, and drawbacks of incorporating play therapy into a comprehensive school counseling program. While this study's data suggest that perceptions were both initially favorable and significantly impacted post-information, it did not explore any specifics on the impact the use of play therapy has on a school counseling program. It could be useful to explore outcome data in comprehensive school counseling programs of elementary school counselors who integrate play therapy as part of their program and those who do not. This could provide further insight into what, if any, significant impact there is in incorporating play therapy services into elementary counseling programs, and how those services might affect academic or closing-the-gap goals of a counseling program.

Recommendation for Practice

Counselor educators may want to consider how this study's data relates to the way counselors are trained in counselor preparation programs. Of this study's 101 elementary school counselors who indicated they had received prior training in play therapy, the highest number of responses (34 responses; 33.7%) indicated they had pursued play therapy training, but no required or elective course in play therapy was offered in their graduate program. This seems to indicate a desire by school counselors to pursue this kind of training. While this study focused on

the perceptions of school counselors, programs that offer clinical or marriage and family coursework options may also benefit from introducing students to a skillset that is beneficial when supporting the mental health needs of children. Courses in play therapy could be structured in a variety of ways depending on when it would be offered within a program's scope and sequence of courses and the prerequisites for enrolling in the class. Counselor educators could choose to offer the course in a near-practicum format, with students working directly with children in a fully equipped playroom on campus during class meetings, or a course could be more lecture- and observation-based, with students watching videoed or live play therapy sessions, or practicing skills with pre-recorded sessions of play without direct contact with children. Courses could be designed to meet CACREP standards of professional identity, human growth and development, and helping relationships, while also aligning with APT's educational outline for students who may be interested in pursuing an RPT or SB-RPT in the future.

Additionally, the data from this study seem to suggest that elementary school counselors are an untapped population that is ripe for training and supervision in play therapy but may be experiencing some barriers to pursuing that training and supervision. Based on the pre-information scores, elementary school counselors who participated in this study already saw play therapy as valuable, but only 52.9% of this study's respondents had any kind of prior training in it, and far less (8.9%) have pursued the extensive training and supervision necessary to hold an active play therapy credential from APT. These numbers in conjunction with the high regard the participants had for play therapy seems to suggest a disconnect between attitudes towards and training in play therapy among elementary school counselors. Advocacy for the accessibility of play therapy training and supervision for elementary school counselors is warranted based on these results.

Conclusion

This quantitative study sought to provide data on elementary school counselors' perceptions on the utility of play therapy. A one-group pretest-posttest design was implemented and found statistical significance in the pre-test and post-test scores of the study's sample and in the initial and post-information perceptions of participants based on their prior training status in play therapy. There was no statistical significance based on the community classification of a participant's employment setting or the Title I funding status of a participant's building of employment. Understanding how elementary school counselors perceive the utility of play therapy and the factors that may or may not contribute to those perceptions provides valuable information for possible future research and practice.

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Appendix A - IRB Approval Letter



TO: Yang Yang
Spec Ed, Counsel & Student Aff
Manhattan, KS 66506

Proposal Number: IRB-11170

FROM: Rick Scheidt, Chair
Committee on Research Involving Human Subjects

DATE: 04/20/2022

RE: Proposal Entitled, "Elementary School Counselors' Perceptions of the Utility of Play Therapy."

The Committee on Research Involving Human Subjects / Institutional Review Board (IRB) for Kansas State University has reviewed the proposal identified above and has determined that it is EXEMPT from further IRB review. This exemption applies only to the proposal - as written – and currently on file with the IRB. Any change potentially affecting human subjects must be approved by the IRB prior to implementation and may disqualify the proposal from exemption.

Based upon information provided to the IRB, this activity is exempt under the criteria set forth in the Federal Policy for the Protection of Human Subjects, **45 CFR §104(d), category:Exempt Category 2 Subsection ii.**

Certain research is exempt from the requirements of HHS/OHRP regulations. A determination that research is exempt does not imply that investigators have no ethical responsibilities to subjects in such research; it means only that the regulatory requirements related to IRB review, informed consent, and assurance of compliance do not apply to the research.

Any unanticipated problems involving risk to subjects or to others must be reported immediately to the Chair of the Committee on Research Involving Human Subjects, the University Research Compliance Office, and if the subjects are KSU students, to the Director of the Student Health Center.

Electronically signed by Rick Scheidt on 04/21/2022 3:29 PM ET

Appendix B - Permission to Use Instrument

Re: FW: Permission to use instrument

From: Margaret Hindman <mlh0012@gmail.com>
Sent: Wednesday, March 30, 2022 7:41 AM
To: Nicole Carleton <ncarleton@ksu.edu>; Hindman, Margaret L <mhindman@sbu.edu>
Cc: Kristi Leann Perryman <klperry@uark.edu>; Samantha Elizabeth Robinson <sewrob@uark.edu>
Subject: Fwd: FW: Permission to use instrument

This email originated from outside of K-State.

Nicole,

I am excited to hear that you are interested in using the Play Therapy Utility Inventory! Thank you for reaching out and asking. You may use it. I just ask that you cite the below two studies and let me know what you find at mlh0012@gmail.com or mhindman@sbu.edu. Included in this email are also two of my mentors and colleagues who were a part of the research project.

Please note the information about the creation and limitations of the inventory outlined in detail in my dissertation cited below (especially see chapter 3 and page 80 which I made a screenshot of and is attached). Please note that the instrument should be regarded as more of a questionnaire than as a standardized instrument. I hope your dissertation goes really well and I look forward to learning about what you find. If you are willing, I'd love to hear a bit about what you plan to do.

Hindman, M. L., Perryman, K. L., & Robinson, S. E. (2022). The adult public's perception of the utility of play therapy. *International Journal of Play Therapy*, 31(1), 34-45. <https://doi.org/10.1037/pla0000164>

Hindman, M. The adult public's perception of the utility of play therapy. [Doctoral Dissertation, University of Arkansas]. ScholarWorks@UARK. <https://scholarworks.uark.edu/etd/3751/>

Thanks again!

Margaret L. Hindman, PhD, LPC (Arkansas), RPT
Assistant Professor
Counselor Education
St. Bonaventure University
Member-at-Large for Arkansas Association for Play Therapy (ArAPT)

[Dropouts: che / her / here](#)

Appendix C - Informed Consent

You are invited to participate in a research study entitled, “Elementary School Counselors' Perceptions of the Utility of Play Therapy.” This study is being conducted by Nicole Carleton, a doctoral candidate at Kansas State University, as part of her doctoral dissertation with IRB #11170.

The purpose of this quantitative study is to gain an understanding of how elementary school counselors perceive the utility of play therapy. The data collected will be analyzed to explore how information about play therapy might impact school counselors’ perceptions and if there is any relationship between prior training in play therapy or population served on these perceptions.

This survey is anonymous. No information about names, email addresses, and/or institutions will be collected. All data will be stored on an encrypted server and analyzed in an aggregate format. To participate, individuals must be currently licensed/certified and employed as an elementary school counselor and working in the school setting. Participants are asked to answer each question as accurately and honestly as possible. There are no right or wrong answers. It is estimated the survey will take 5-10 minutes to complete. The benefits of this research will identify the effect brief information on play therapy may have on elementary school counselors’ perceptions of its utility. There are no risks or discomforts anticipated for participants, and there is no compensation provided for participating in this study.

If you have any questions or comments about this study, please feel free to contact me at ncarleton@ksu.edu or my dissertation major professor, Dr. Lydia Yang, at yyang001@ksu.edu. Questions regarding this research project should be sent to Rick Scheidt, Chair, Committee on Research Involving Human Subjects, 203 Fairchild Hall, Kansas State University, Manhattan, KS 66506, (785) 532-3224. The IRB Website is available at <http://www.k-state.edu/research/comply/irb/>

I understand that this project is research, and my participation is entirely voluntary. I also understand that if I decide to participate in this study, I may withdraw my consent at any

time and stop participating at any time without explanation, penalty, or loss of benefits, or academic standing to which I may otherwise be entitled. I verify by proceeding with this survey by clicking the link below that I have read and understand this consent form and willingly agree to participate in this study under the terms described.

Appendix D - Email Communications

Subject: Research Participation Request: School Counselor Perceptions of Play Therapy Utility

Dear Participant:

I am a practicing school counselor in Missouri and a doctoral candidate in Counselor Education and Supervision at Kansas State University. I am requesting your assistance with an anonymous online survey study on elementary school counselors' perceptions of the utility of play therapy.

To participate, individuals must be currently licensed/certified and employed as an elementary school counselor and working in the school setting. Participation is voluntary for the online survey and will take approximately 5-10 minutes to complete.

Thank you for your participation in this research study. The goal of this study is to explore the perceptions elementary school counselors have about play therapy, its utility, and whether exposure to brief information about play therapy influences perceptions. All the information collected in the study is anonymous and confidential. Data will be analyzed in the aggregate. The study has IRB approval at Kansas State University, #11170.

For more information on the study and to participate, please click on the following link or copy and paste it into your internet browser to begin.

[Qualtrics survey link]

If you have any questions or comments about this study, please feel free to contact me at ncarleton@ksu.edu or my dissertation major professor, Dr. Lydia Yang, at yyang001@ksu.edu.

Appendix E - Play Therapy Utility Instrument

1. Play is a child's natural way to communicate.

Strongly Disagree Disagree Neutral Agree Strongly Agree

2. Play therapy is useful for those under 3 years old.

Strongly Disagree Disagree Neutral Agree Strongly Agree

3. Play therapy is not useful for children 3 to 12 years old.

Strongly Disagree Disagree Neutral Agree Strongly Agree

4. Play therapy helps children use empathy.

Strongly Disagree Disagree Neutral Agree Strongly Agree

5. Play therapy is useful for children going through change.

Strongly Disagree Disagree Neutral Agree Strongly Agree

6. Children mostly talk to understand their world.

Strongly Disagree Disagree Neutral Agree Strongly Agree

7. Play therapy helps children express feelings.

Strongly Disagree Disagree Neutral Agree Strongly Agree

8. Play therapy is useful for children.

Strongly Disagree Disagree Neutral Agree Strongly Agree

9. Play therapy helps children feel confident.

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

10. Play therapy is useful to learn social skills.

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

11. Children mostly use play to understand their world.

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

12. Play therapy helps children respect themselves.

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

13. Children's brains are not as mature as adults'.

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

14. Play therapy is useful to treat mental issues.

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

Watch the following video (1 minute, 25 seconds).

<https://www.youtube.com/watch?v=reJpo-GaopM&t=5s>



What drink was mentioned in the video?

- a.) Iced tea
- b.) Coke float
- c.) Chocolate milk on the rocks
- d.) Lemonade on the rocks

1. Play is a child's natural way to communicate.

Strongly Disagree Disagree Neutral Agree Strongly Agree

2. Play therapy is useful for those under 3 years old.

Strongly Disagree Disagree Neutral Agree Strongly Agree

3. Play therapy is not useful for children 3 to 12 years old.

Strongly Disagree Disagree Neutral Agree Strongly Agree

4. Play therapy helps children use empathy.

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

5. Play therapy is useful for children going through change.

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

6. Children mostly talk to understand their world.

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

7. Play therapy helps children express feelings.

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

8. Play therapy is useful for children.

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

9. Play therapy helps children feel confident.

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

10. Play therapy is useful to learn social skills.

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

11. Children mostly use play to understand their world.

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

12. Play therapy helps children respect themselves.

Strongly Disagree Disagree Neutral Agree Strongly Agree

13. Children's brains are not as mature as adults'.

Strongly Disagree Disagree Neutral Agree Strongly Agree

14. Play therapy is useful to treat mental issues.

Strongly Disagree Disagree Neutral Agree Strongly Agree

Would you recommend play therapy services in the future?

Very likely Somewhat likely Neither likely nor unlikely Somewhat unlikely Very Unlikely

Would you consider pursuing training and/or credentialing in play therapy in the future?

Very likely Somewhat likely Neither likely nor unlikely Somewhat unlikely Very Unlikely